

State of Utah - Labor Commission**Division of Adjudication**160 East 300 South, 3rd Floor, P.O. Box 146615

Salt Lake City, Utah 84114-6615

(801) 530-6800

laborcommission.utah.gov

Note: PLEASE TYPE OR PRINT IN BLACK INK

<p>_____</p> <p>Medical care provider</p> <p>_____</p> <p>Injured Employee</p> <p>Vs.</p> <p>_____</p> <p>Respondent (Employer)</p> <p>_____</p> <p>Respondent's mailing address</p> <p>_____</p> <p>City, State and Zip Code</p> <p>_____</p> <p>Respondent's phone number</p> <p>_____</p> <p>Respondent's worker's compensation insurance carrier</p>	<p style="text-align: center;">APPLICATION FOR HEARING MEDICAL CARE PROVIDER</p> <p>(NOTE: Include all supporting documentation when this form is filed with the Labor Commission or the Application for Hearing may be returned)</p> <p>I request to have a Claims Resolution Conference scheduled to resolve the issues checked below</p> <p style="text-align: center;"><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
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PETITIONER ALLEGES AND REQUESTS RESOLUTION CONCERNING THE FOLLOWING UNDER TITLE 34A:

1. Date of industrial injury: Month _____ Date _____ Year _____.
2. Medical charges at issue (you must attach an itemized, detailed account of the services rendered, the date of the services, the charges for the services, and the correct RBRVS billing code).
3. Amounts paid by respondents to date _____
4. The injuries employee sustained from the accident are: _____

5. If you are billing for restorative services you must include RSA forms.

Petitioner verifies that the above information is true and correct to the best of petitioner's information and belief.

Printed Name of Attorney for Petitioner State Bar #

Signature of Attorney for Petitioner

Mailing Address for Attorney for Petitioner

City/State/Zip Code

()
Telephone Number

()
FAX E Mail Address

Signature of Petitioner Date

Mailing Address of Petitioner

City/State/Zip Code

()
Petitioner's Telephone Number

Petitioner's Social Security Number

If you know the name and address of the adjuster or third party administrator that you have dealt with concerning your claim please include that information:

Name of adjuster or third party administrator

Mailing address for adjuster or third party administrator

City/State/Zip Code